

CULTURAL COMPETENCE PRACTICE MODEL

September 2, 2003

GOAL: Cultural, ethnic and linguistic diversity will play a critical and crucial role in mental health care that results in services that are effective and sensitive; delivered by knowledgeable and skilled clinicians in collaborative manner to assist individuals to achieve personal well-being.

TARGET POPULATIONS: The identified populations are children, youth and adults from historically underserved and underrepresented racial/ethnic minority groups and the Deaf, with an understanding that additional cultural factors include gender, age, language, immigration status, disability, sexual orientation, religion, and socioeconomic status, which run across all groups.

OVER-ARCHING PHILOSOPHY: Culturally competent service delivery evolves out of three areas: a) guiding principles (values and attitudes), b) training, and c) skills. Service providers become culturally competent through education, self discovery, and experience.

A. Guiding Principles (Values and Attitudes):

1. Principle of Respect

- a. Recognize the inherent worth of all human being regardless of how different they may be from oneself, including respect of roles of family members and community structures, hierarchies, values, and beliefs within the client's culture.
- b. Give value to a client's religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychological functioning, and expressions of distress. This is essential to effective service delivery, even if client's world perspective will increase the care provider's ability to provide meaningful and comprehensive care, regardless of his/her own personal perspectives and values.

2. Principle of Consumer/Family-Driven and Community-Based System of Care

- a. Family and community play a significant role in the life of consumers.
- b. Consumers and families are the most important participants and collaborators in the service planning, implementation and evaluation process.
- c. Family is defined by function rather than bloodlines in many ethnic cultures. Individuals from these groups generally conceive of family much more broadly than mainstream individuals.
- d. Self-help concepts from the racial/ethnic/deaf cultures are valued.
- e. Familiar and valued community resources from the client's culture are valued.
- f. The least restrictive, appropriate and community-based environment for treatment is valued.

3. **Principle of Natural Support**
Natural community support and culturally competent practices are viewed as an integral part of a system of care which contributes to desired outcomes in a managed care environment. Traditional healing practices are used when relevant and possible.
4. **Principle of Sovereign Nation Status**
The systems of care for American Indian and Alaska Native who are members of sovereign nations must acknowledge the right of those sovereign nations to participate in the process of defining culturally competent managed care.
5. **Principle of Collaboration and Empowerment**
Consumers from diverse groups are supported in their desire to collaborate with service systems to determine their course of treatment. The greater the extent of this collaboration, the better the chance of recovery and long-term improved functioning.
6. **Principle of Holism**
The value of a holistic approach to care is recognized and is implemented in education/prevention/early intervention, clinical work, policies, and standards, recognizing its importance to diverse groups.
7. **Principle of Feedback**
Legitimate opportunities for feedback from diverse groups is encouraged in order to enhance desired outcomes of their activities. Where such opportunities for feedback are absent, there is a greater likelihood that services will not be congruent with the needs of consumers and will result in lower levels of consumer satisfaction, as well as the agency missing the chance to make culturally specific corrections in its service delivery system.
8. **Principle of Outcomes**
Meaningful outcomes for consumers from diverse groups and their families are determined by the consumers themselves and should reflect assessment of services relative to the problems that prompted their seeking help.

B. GUIDELINES FOR PRACTICE WITH DIVERSE POPULATIONS:

Goal: Agencies will provide personnel with resources and training to effectively build the knowledge and skills necessary to improve service delivery and quality of care. Knowledge and skills include, but are not limited to, the following:

1. **Knowledge** is gained through workshops, classes, and/or printed materials that:
 - A. Enhances understanding and awareness of each individual's personal cultural, moral, and social/cultural values, beliefs, and biases and sensitivity to how these factors may enhance interactions with others or may interfere with promoting the welfare of others. This is an on-going process that requires each employee to constantly reevaluate his/her competence, attitudes, and effectiveness in working with diverse populations.

- B. Emphasizes the power differential between oneself and others in order to diminish differences, and teaches personnel to use power for the advantage of others rather than unwittingly to abuse it.
 - C. Develops a knowledge-base of target groups (i.e. those groups identified as living within the geographic boundaries of the agency as determined by demographic data) through the study of group or cultural norms, including specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expression of major client groups, in order to recognize individual differences within the larger context.
 - D. Provides an awareness of culture-bound syndromes (i.e. definitions of illness, causation and treatment that are culturally identified and defined) associated with diverse groups and their subcultures, including differences in thresholds of psychiatric distress and tolerance of symptomatology by their natural support systems. Understanding includes knowledge of healing practices and the role of belief systems (religion and spirituality) in the treatment of diverse clients.
 - E. Encourages employees to question the applicability of theories or treatment models commonly used may not apply to diverse groups, because they have been developed with research based on people from the dominant culture and therefore, may not apply or differently apply to form non-dominant cultures.
 - F. Enables personnel to recognize the reality, variety, and implications of all forms of oppression in society, and the impact of discrimination and oppression on the daily lives of individuals from diverse cultures.
 - G. Provides personnel with information on the services available in the community and broader society for individuals from diverse groups. This information is comprehensive, including names of agencies and available services, location referral procedures, access criteria, etc.
2. **Skill acquisition** that enable service providers (i.e. any employee of an agency that interacts with clients and/or engages in direct client care, such as counselors/therapists/psychiatrists, etc.) to:
- A. Ensures that the client, the client's family, and appropriate support network are engaged as the base system of care in assessment, treatment planning, service delivery and evaluation of services.

- B. Utilize the client as a cultural guide, rather than assuming the role of expert. This is accomplished through respect, active listening, and a strength-based orientation, allowing the client to educate the provider about the cultural aspects determining causation, assessment, and treatment of problem. Methods such as Ethnographic Interviewing are extremely helpful in the process. Another effective model is “Strategies for Clinical Cultural Assessment and Interactions,” (Miller, 1982).
- C. Utilize culturally sensitive interviewing tools, such as Kleinman’s (1981) Tool to Elicit Health Beliefs in Clinical Encounters and Pfiffner’s (1981) Cultural Status Exam. These methods result in treatment plans that are compatible with the conceptual framework and community environment of clients and family members and are therefore relevant to their culture and life experiences, leading to desired outcomes. Care plans developed in a culturally competent manner include:
 - 1. Family and cultural strength
 - 2. Traditional healing practices
 - 3. Religious and spiritual resources
 - 4. Natural support system
 - 5. Community organizations and self-help groups within the client’s identification/affiliation
 - 6. Coordination and mental and physical health, as well as other source services
 - 7. Educational components that explain the problems/conditions being treated, treatment methods, concepts of recovery, rehabilitation, prevention, and self-help approaches.
- D. Provide, whenever possible, information in writing along with oral explanations, in the preferred language identified by the client at intake and throughout the treatment process.
- E. Be, whenever possible, bilingual and culturally competent. When such staff are not available, trained and/or skilled interpreters who are knowledgeable in the mental health field can be used. Use of family member, especially children, is prohibited. Linguistic assistance is made available according to the client’s preference from intake to conclusion of services.
- F. Ensure that consent is truly informed, keeping in mind diversity issues and cultural/linguistic differences. This requires provider to be especially careful to be open, honest, and straightforward, remembering that persons who are oppressed may be distrustful or overly trustful of those in authority.
- G. Be conscious of client’s historical and personal experience with oppression and the impact of this on the helping relationship and the treatment plan. As a result, provider assess accurately the source of difficulties, apportioning causality appropriately between individual, situational, and cultural factors.

- H. Respect privacy and confidentiality according to the wishes of clients, and explains fully any limitations on confidentiality that may exist.
- I. Evaluate the cultural meaning of dual/multiple and overlapping relationships in order to show respect and to avoid exploitation of the client. Service provider explains, at intake and through treatment process, potential boundary issues.
- J. Seek to understand culturally defined beliefs and/or behaviors that may conflict with the law in the city and/or state in which treatment occurs, and through rapport building helps the client understand and comply with pertinent laws. Such areas may include, but are not limited to, physical or sexual abuse, child disciplinary practices, healing practices, and child rearing practices (which may include the age at which children are left alone, or in charge of younger children).

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APPENDIX

Kleinman, Arthur (1980). *Patients and Healers in the Context of Culture*. The Regents of the University of California, University of California Press.

Kleinman suggest the following questions to elicit an explanatory model:

1. What do you think cause your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?
5. What are the chief problems your sickness has caused you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to get from treatment?

Additional tools for Sensitive Interviewing:

1. Individual or family illness prototypes:
 - a. What are your ideas or concerns about your illness based on your previous personal experience?
 - b. What are your ideas or concerns about illness based on the experiences of other family members or friends?
2. Individual or family patient requests:
 - a. What type of help would you (your family member) like (hope, wish, want) to receive from the practitioner?

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CULTURAL STATUS EXAM QUESTIONS:

1. How would you describe the problem that has brought you to me?
 - a. Is there anyone else with you that I can talk to about your problem? (If yes, to significant other: Can you describe X's problem?)
 - b. Has anyone else in your family/friend network helped you with this problem?
2. How long have you had this (these) problem(s)?
 - a. Does anyone else have this problem that you know? (If yes, describe them, how old they are, and their different presentations/symptoms.)
3. What do you think is wrong, out of balance, or causing your problem?
 - a. Who else do you know who has, or gets this kind of problem?
 - b. Who, or what kind of people, don't get this problem?
4. Why has this problem happened to you, and why now?
 - a. Why has it happened to (the involved party)?
 - b. Why did you get sick and not someone else?
5. What do you think will help to clear up your problem?
 - a. If they suggest specific tests, procedures, or drugs, ask them to further define what they are and how they will help.
6. Apart from me, who else do you think can help you get better?
 - a. Are there things that make you feel better, or give you relief, that doctors don't know about?